STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  X3) DATE SURVEY COMPLETED 01/27/2012			
	PROVIDER OR SUPPLIE	R	STREET 7510 F	ADDRESS, CITY, STATE, ZIP CODE ROSEGATE DR NAPOLIS, IN 46237	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	State Licensure included the Inv IN00102153.  Complaint IN00 Unsubstantiated Survey dates: Jacob 2012  Facility number Provider number AIM number: 20 Survey Team: Courtney Mujic 24, 25, 26, 2012 Barb Hughes, R 2012)	, due to lack of evidence. anuary 23, 24, 25, 26, 27,  : 011149 r: 155757 00829340  , RN - TC (January 23, ) N (January 24, 25, 26, 27,  Iedical Surveyor  oe:	F0000	Please accept this 2567 Plan Correction for the Health Survending January 27, 2012 as the Provider's Letter of Credible Allegation. This Provider respectfully requests a Post Survey Revisit on or after February 26, 2012.	rey

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

S4YX11

Facility ID: 011149 (X6) DATE

TITLE

PRINTED: 02/17/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  OF CORRECTION IDENTIFICATION NUMBER:  155757	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 01/27/2012
	PROVIDER OR SUPPLIER	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION
	Total: 145			
	Sample: 24			
	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.			
	Quality review 2/02/12 by Suzanne Williams, RN			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S4YX11

Facility ID: 011149

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155757	B. WING		01/27/2012	
				T ADDRESS, CITY, STATE, ZIP CODE	l.	
NAME OF F	PROVIDER OR SUPPLIE	R		ROSEGATE DR		
ROSEGA	ATE VILLAGE			ANAPOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0282		vided or arranged by the				
SS=E		rovided by qualified persons th each resident's written				
	plan of care.	in each resident's written				
,	ι .	vation, interview, and	F0282	What corrective action(s) wi	II 02/26/2012	
			10202	be accomplished for those	02/20/2012	
	· ·	he facility failed to follow		residents found to have bee	n	
	1 ^ *	rs for 2 of 4 residents		affected by the deficient		
	· /	eviewed for correct insulin		practice? · Residents #106 a	and	
	administration a	and 2 of 11 residents		#96 were immediately assess	ed	
	(#143, #103) rev	viewed for diet orders, in a		to ensure blood sugars did no		
	sample of 24.			require further treatment. • M		
	1			tickets for residents #143 and		
	Findings include	a·		#103 have been updated to		
	Tindings include	<b>.</b> .		reflect current physician order and both receive specialized	8	
	4 701 11 1	10 7 11 11100		diets. How will you identify		
		record for Resident #106		other residents having the		
	was reviewed or	n 1/27/12 at 10:00 a.m.		potential to be affected by the	ne	
				same deficient practice and		
	The diagnosis for	or Resident #106 included,		what corrective action will b	e	
	but was not limi	ted to: diabetes mellitus.		taken? · Residents receiving		
				sliding scale insulin have bee	n	
	A recanitulation	of the January 2012		identified and will be assesse		
	_	rs, indicated Humalog		correct insulin administration.		
	1 *	•		All residents with specialized		
	`	nt of blood sugar/glucose		orders have been identified. Notickets for these residents have		
	· /	e given per sliding scale		been audited to ensure service		
	of subsequent bl	lood sugars (BS) from an		are being provided in accorda		
	Accucheck mea	surement. The sliding		with each resident's written pl		
	scale was BS 13	1-180=1 unit of		of care. What measures will		
	Humalog, BS of	f 181-240= 2 units of		put into place or what system	mic	
	•	f 241-300=3 units of		changes you will make to		
	_	f 301-350=4 units of		ensure that the deficient		
	I -			practice does not recur?		
		51-400=5 units of		Residents requiring insulin		
		ose greater than 400, give		coverage per sliding scale wil		
	6 units of Huma	log and call MD (medical		have the amount of insulin administered documented on	tho	
	doctor).			MAR and/or Capillary Blood	u IC	
				Glucose Monitoring Tool by		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155757	B. WIN			01/27/	2012
			D. (VII)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			OSEGATE DR		
ROSEGA	ATE VILLAGE				APOLIS, IN 46237		
		THAT THE AT MINING OF THE PROPERTY OF THE		l .			(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
TAG	<b>+</b>			IAU	licensed nurses. · An in-service		DATE
		Capillary Blood Glucose			will be completed by the Direct		
		l indicated the resident's			of Nursing and/or designee on		
	,	S) were checked and in			February 16, 2012 to licensed		
	the range require	ing Humalog insulin			nurses on sliding scale insulin		
	coverage per slic	ding scale. On the			administration and documenta		
	following dates	and times the treatment			requirements. The Director of		
	_	od sugar was blank:			Nursing Services and/or desig	nee	
		m., BS=224, 2 units of			will assign a licensed nurse to review the MAR's of all resider	nts	
		I have been administered			receiving sliding scale insulin	110	
		m., BS=157, 1 unit of			daily to ensure administration		
					occurs per physician order.	An	
	_	I have been administered			in-service will be completed by	/	
		m., BS=158, 1 unit of			the Dietary Services Manager	on	
	_	I have been administered			February 23, 2012 to nursing,		
	1/8/12 at 6:00 a.	m., BS=175, 1 unit of			food service and therapy staff		
	Humalog should	I have been administered			regarding facility processes for communicating and ensuring	ſ	
	1/9/12 at 6:00 a.	m., BS=151, 1 unit of			residents receive physician		
	Humalog should	l have been administered			ordered specialized diets. The	ne	
	_	m., BS=217, 2 units of			Dietary Services Manager and	l/or	
	_	I have been administered			designee will conduct tray aud	its	
	_	a.m., BS=160, 1 unit of			every other day to ensure		
					resident meals are prepared a		
	_	I have been administered			served per physician order. Ho the corrective action (s) will I		
		a.m., BS=158, 1 unit of			monitored to ensure the	Je	
	_	I have been administered			deficient practice will not rec	ur.	
	1/18/12 at 6:00 a	a.m., BS=276, 3 units of			i.e., what quality assurance	····,	
	Humalog should	I have been administered			program will be put into plac	e?	
	1/25/12 at 6:00 a	a.m., BS=161, 1 unit of			· A CQI audit tool will be utiliz	ed	
	Humalog should	l have been administered			by the Director of Nursing and		
					designee to monitor compliand	ce	
	In an interview v	with the DoN (Director of			with documentation of insulin	dita	
		27/12 at 3:30 p.m., she			coverage per sliding scale. Au will be completed weekly X 4	นแร	
	indicated that sh	• .			weeks, monthly X 2 months, a	nd	
					quarterly thereafter for at least		
		correct amount of insulin			two quarters. · A CQI audit to		
	was given on the	e above dates.			will be utilized by the Dietary		
					Services Manager to monitor		

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Event ID: S4YX11

Facility ID: 011149

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE : COMPL	
ANDILAN	OI CORRECTION	155757	A. BUILDI	NG	00	01/27/	
			B. WING	TREET A	DDRESS, CITY, STATE, ZIP CODE	•=	
NAME OF F	PROVIDER OR SUPPLIE	R			OSEGATE DR		
ROSEGA	ATE VILLAGE				APOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIES	l l	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1710		record for Resident #143	1	710	compliance of residents receiv	ing	DITTE
		n 1/25/12 at 4:10 p.m.			physician ordered specialized		
		1			diets. Meal observations will be completed weekly X 4 weeks,	е	
	The diagnoses for	or Resident #143			monthly X 2 months, and		
	included, but we	ere not limited to:			quarterly thereafter for at least		
	diabetes mellitus				two quarters. · Results of thes evaluation processes will be	se	
	depression, and	dementia.			presented to the CQI Committee monthly to review for complian		
	A recapitulation	of the January			and follow-up. Identified		
	1 -	ers indicated that Resident			noncompliance may result in s re-education and/or disciplinar		
		er for a mechanical soft,			action.	y	
		hydrate, thin liquids, and					
	fruit and yogurt	at all 3 meals.					
	During an obser	vation of Resident #143					
	eating dinner on	1/25/12 at 5:05 p.m., she					
	was observed w	ithout a fruit plate and					
	yogurt as part of	f her meal.					
	During an obser	vation of Resident #143					
		1/26/12 at 11:38 a.m., she					
		ithout a fruit plate and					
	yogurt as part of	f her meal.					
	_	view with the Dietary					
	_	6/12 at 1:15 p.m., she					
		e kitchen staff probably					
		fruit and yogurt on meal tray for the above					
	dates.	mear may for the above					
	dates.						
	3. The clinical r	record for Resident #103					
	was reviewed or	n 1/24/12 at 3:00 p.m.					

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Event ID: S4YX11

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If continuation sheet

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			(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		155757	B. WING			01/27/	2012
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
DOSEGA	ATE VIII ACE				DSEGATE DR		
	ATE VILLAGE				APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES	DI	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
TAG	The diagnoses for	*		IAG			DATE
	included, but we						
	· · · · · · · · · · · · · · · · · · ·	ension, depression, and					
	twisted colon.	ension, depression, and					
	twisted colon.						
	A recapitulation	of the January					
	_	rs indicated that Resident					
		er for a regular diet and a					
	fruit plate at mea	•					
	Truit plate at med	no.					
	During an observ	vation of Resident #103					
	_	1/25/12 at 4:50 p.m., she					
		thout a fruit plate as part					
	of her meal.	thout a frait plate as part					
	of her mean.						
	During an observ	vation of Resident #103					
		1/26/12 at 11:45 a.m., she					
		thout a fruit plate as part					
	of her meal.	thout a franc place as part					
	During an interv	iew with the Dietary					
		5/12 at 1:15 p.m., she					
	1	e did not know that					
		ad an order for a fruit					
		d the order was most					
	likely overlooke						
	1	ecord for Resident #96					
		1/26/12 at 10:00 A.M.					
	The diagnosis fo	r Resident #96 included,					
	_	ted to, diabetes mellitus.					
		•					
	Recapitulation of	f a physician order dated					
	_	d Novalog (insulin					

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Event ID: S4YX11

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/27/2012
NAME OF	PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP CODE  OSEGATE DR	
ROSEG	ATE VILLAGE			IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	be given per slid (BS) from an Adand the results a amounts should Diabetic Flow S for Novolog adm 141-170=1 unit, 201-230 = 3 unit 261-280= 5 unit 301-350 7 units, 401-450 =10 unit The Blood Gluc (referred to as Dused for December #96's blood sugat following dates treatment for the 12/2/11 at 6 A.N. have been admin 12/3/11 at 4 P.N. have been admin 12/3/11 at 4 P.N. have been admin 12/4/11 at 4 P.N. have been admin 12/5/11 at 6 A.N.	ose Monitoring Tool plabetic Flow Sheet) ber indicated Resident hars were checked on the and times but the insulin be blood sugars were blank: A.=151 - 1 unit should histered A.=352 - 8 units should histered A.=185 - 2 units should histered A.=310 - 7 units should histered A.=332 - 7 units should histered A.=147 - 1 unit should histered A.=147 - 1 unit should histered A.=292 - 6 units should			

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Event ID: S4YX11

Facility ID: 011149

If continuation sheet

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PRINTED: 02/17/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155757	(X2) MULTIPLE CO  A. BUILDING  B. WING	00 	(X3) DATE COMPI 01/27	LETED
	PROVIDER OR SUPPLIER	7510 R	ADDRESS, CITY, STATE, ZIP COD OSEGATE DR APOLIS, IN 46237	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	have been administered 12/7/11 at 4 P.M.=298 - 6 units should have been administered 12/8/11 at 6 A.M.=224 - 3 units should have been administered 12/8/11 at 4 P.M.= 315 - 7 units should have been administered 12/9/11 at 6 A.M.=220 - 3 units should have been administered 12/10/11 at 6 A.M.=194 - 2 units should have been administered  On 1/27/12 at 12:30 P.M. during an interview with the DON, she indicated their facility did not have any other documentation of the units given for Resident #96.  3.1-35(g)(2)				

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Event ID: S4YX11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2)		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155757			<del></del>	01/27/	2012
			B. WIN		ADDRESS SITU STATE ZID SODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DOCECA	TEVULACE		7510 ROSEGATE DR INDIANAPOLIS, IN 46237				
RUSEGA	ATE VILLAGE			INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0309		st receive and the facility					
SS=E	-	necessary care and					
		or maintain the highest					
	practicable physic	being, in accordance with					
		e assessment and plan of					
	care.	o accessment and plan of					
'	Based on record	review and interview, the	F03	09	What corrective action(s) wil	·	02/26/2012
		ensure residents were			be accomplished for those		
		eived treatment for			residents found to have beer	1	
		l movements in order to			affected by the deficient		
					practice?		
	•	health in 4 of 14			Bowel assessments by		
		ed for bowel movement			licensed nurse were immediate completed for residents #29,	eıy	
	assessment in a t	otal sample of 24.			#132, #50 and #40 to ensure		
	Residents #29, #	132, #50, #40.			residents received treatment for	or	
					absence of bowel movements	, if	
	Findings include	·			any.		
	C				How will you identify other		
	1 The clinical re	ecord for Resident #132			residents having the potentia	al	
		1/24/12 at 11:00 a.m.			to be affected by the same		
					deficient practice and what	•	
	The diagnoses for				corrective action will be take  BM records for all records		
	*	re not limited to: obesity,			were audited to identify any	us	
	· ·	sonism, and chronic back			residents who had not had a		
	pain. The medica	al record also contained			bowel movement in 3 consecu	itive	
	an 11/13/2011 as	ssessment of a BIMS			days. Any identified residents		
	(brief interview t	for mental status) score of			were provided a treatment as		
	13 out of 15 poss	sible points, meaning that			physician prescribed.		
	the resident was	alert and oriented and			An audit was completed     ansure that residents with earse		
		d questions and answer			ensure that residents with care plans for risk/actual constipation		
	appropriately.	1			have physician prescribed	J11	
	appropriately.				treatments for the absence of		
	Dagardi	diantad a manting deserted			bowel movements.		
		ndicated a routine doctor's			What measures will be put in	to	
	1	ylene Glycol (Miralax)			place or what systemic		
	•	mix 17 GM in 8 oz of			changes you will make to		
	liquid and give b	y mouth once daily.			ensure that the deficient		
	l		1		practice does not recur?		1

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Event ID: S4YX11

Facility ID: 011149

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIWINDING	00	COMPLETED
		155757	A. BUILDING		01/27/2012
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R			
DOSECA	\TE\/     ACE			OSEGATE DR	
RUSEGF	ATE VILLAGE		INDIAN	IAPOLIS, IN 46237	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		5.112
	Resident #132 d	id not have any		The Director of Nursing	
	medication pres	cribed as needed for		Services and/or designee will	
	constipation.			assign a licensed nurse to rev	• • • • • • • • • • • • • • • • • • •
	1			all resident BM records daily t identify any residents who have	
	Resident #132's	December and January		not had a bowel movement in	• • • • • • • • • • • • • • • • • • •
		nt records indicated		consecutive days.	
				· Residents identified as	not
		id not have a BM from		having a BM in 72 hours will h	nave
	12/25/11 throug	h 01/09/12.		appropriate treatments initiate	d
				as physician prescribed to	
	Resident #132's	December 2011 and		maintain healthy bowel	
	January 2012 M	AR (Medication		elimination patterns.  An in-service will be	
	Administration 1	Record), indicated that no		completed by the Director of	
		given PRN (as needed)		Nursing and/or designee on	
		In the Nurse's Notes,		February 16, 2012 to nursing	staff
	_	lication that there was any		regarding facility policies to	
		•		maintain healthy resident bow	rel
		sments done and no MD		elimination.	
	<b>1</b> `	notification for no bowel		How the corrective action (s	•
	movements bety	veen the dates of		will be monitored to ensure	
	12/25/2011 and	01/09/2012.		deficient practice will not red i.e., what quality assurance	cur,
				program will be put into place	-02
	A care plan for o	constipation indicated		A CQI audit tool will be	,,,,
	•	08/11, 11/30/2011, and		utilized by the Director of Nurs	sing
	~	e intervention that an MD		and/or designee to monitor fa	
		ere is no BM for 3 days.		compliance with resident bow	el
		•		elimination procedures weekly	
		ntion dated 05/26/12		4 weeks, monthly X 2 months	• • • • • • • • • • • • • • • • • • •
		D should be notified prn		and quarterly thereafter for at least two quarters.	
	` ′	axative order or if		Results of these evalua	tion
	interventions we	ere ineffective. Another		processes will be presented to	
	intervention on	the care plan dated		the CQI Committee monthly to	
	05/26/2011 indi	cated administer laxative		review for compliance and	
	as ordered.			follow-up. Identified	
				noncompliance may result in	
	Interview with L	Resident #132 on		re-education and/or disciplina	ry
				action.	
	1/20/2012 at 2:3	5 p.m. indicated that the			[

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	A. BUILDING		NSTRUCTION  00	(X3) DATE COMPL 01/27/	ETED
	PROVIDER OR SUPPLIER		75	10 RC	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN 46237	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	resident did not a period of time be and that if she has going for more thave told someon.  2. The clinical rewas reviewed on The diagnoses for but were not lime hypertension, right The 12/17/12 Act data set) indicate assistance/2 persumbulation (wall occurred only on physical assist, hassistance/1 persuse - extensive a physical assist, be continent.  The January, 201 recapitulation or indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz. before a.m. meal effective 12/13/1 laxative) 30 ml occurred only on indicated Mirala mixed with 8 oz.	recall having any long retween bowel movements and any problem of not than two days she would the (a nurse or an aide.)  record for Resident #50 1/25/12 at 10:30 a.m.  or Resident #50 included, aited to: constipation, the fibula/tibia fracture.  Imission MDS (minimum red: transfer - extensive on physical assist, as in room) - activity ace or twice/ 1 person ygiene - extensive on physical assist, toilet sesistance/1 person owel continence - always  1.2 physician's ders for Resident #50 as (a laxative) 17 grams of water p.o. (by mouth) daily at 6:00 a.m.  1, Milk of Magnesia (a					

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	OF CORRECTION IDENTIFICATION NUMBER:  155757	A. BUILDING	00	COMPLETED 01/27/2012
NAME OF I	PROVIDER OR SUPPLIER	B. WING STREET ADDR 7510 ROSE	RESS, CITY, STATE, ZIP CODE	3112112
ROSEGA	ATE VILLAGE	INDIANAPO	DLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	no bowel movements effective 12/14/11.  The 12/5/11 constipation care plan indicated Resident #50 had a potential for constipation related to impaired mobility and pain meds (medications). The goal indicated on the care plan was for the resident to have a BM (bowel movement) at least q (every) 3 days. The approaches indicated on the care plan were to administer laxative as ordered, notify MD prn (as needed) for laxative order or if interventions ineffective, and to record BM's on the BM log.  Review of the December 2011 Bowel and Bladder Detail Report indicated Resident #50 had a BM on 12/18/11, but did not have the next BM until 12/23/11. No information could be found in the clinical record to indicate any interventions including any PRN medications were given in this 5 day time period or that the MD was notified. Review of the January, 2012 Bowel and Bladder Detail Report indicated Resident #50 had a BM on 1/7/12, but did not have the next BM until 1/12/12. No information could be found in the clinical record to indicate any interventions including any PRN medications were given in this 5 day time period or that the MD was notified.  During interview with Resident #50 on			

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	OF CORRECTION  OF CORRECTION  155757  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  155757	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 01/27/2012
	PROVIDER OR SUPPLIER ATE VILLAGE	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN 46237	_
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	1/25/12 at 3:30 pm, she indicated she remembered being constipated during these time frames and that it was uncomfortable for her. She also indicated the staff never asked her if she needed a laxative.			
	During interview with the DON on 1/26/12 at 10:55 a.m., she indicated she couldn't find any information to indicate any interventions were done or the MD was notified regarding these two 5 day periods of no bowel movements for Resident #50.			
	The Bowel Elimination Policy provided by the DON on 1/26/12 at 10:30 a.m. stated, "7. A resident listing will be completed by the assigned charge nurse of resident(s) who have not had a bowel movement for 3 consecutive days.  8. Any resident not having a bowel movement for 3 consecutive days, will be given a laxative or stool softener, as prescribed by the physician, at the end of the 3rd day.  9. Resident(s) not having result from the laxative or stool softener will be given an enema, if ordered by the physician.  10. If by the 4th afternoon, the resident(s) has not had results, the nurse will do an abdominal assessment, chart the results of the assessment, and notify the physician			

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MUL A. BUILD B. WING		NSTRUCTION  00	(X3) DATE COMPL <b>01/27</b> /	ETED
NAME OF I	PROVIDER OR SUPPLIE				ADDRESS, CITY, STATE, ZIP CODE		
ROSEGA	ATE VILLAGE				DSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	for further order	."					
		ecord for Resident #29 n 1/25/12 at 4:15 p.m.					
	but was not limi	or Resident #29 included, ted to: constipation, Il reflux disease, and dementia.					
	BM (bowel mov	of resident #29's October rement) records indicated 9 did not have a BM from h 10/25/11.					
	9/12/11, one of tabdominal asses for bowel sound tenderness. And care plan indicat notified if there	r constipation, dated the interventions indicated sments should be done s, distention, pain, and other intervention on the ted the MD was to be was no BM for 3 days. A m was to administer edered.					
	October 2011 M Administration I medication was for constipation. Milk of Magnes PRN for constip MAR indicated	of Resident #29's AR (Medication Record), indicated no given PRN (as needed) There was an order for ium (MOM) to be given ation. A review of the that no MOM was given e time frame. In the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155757		A. BUILDING 00 COMPLETED 01/27/2012		
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROID DEFICIENCY)	BE COMPLETION	
TAG	Nurse's Notes, there was no indication there were any abdominal assessments done during the above time frame or a MD (medical doctor) notification was done for no BM for 3 days.  In an interview with the DoN (Director of Nursing), on 1/27/12 at 12:15 p.m., she indicated she was unable to determine if there were any interventions done to promote a BM.  4. A record review on 1/24/12 at 3:30 P.M. of a Bowel and Bladder Report for Resident #40 indicated that a BM did not occur for 7 days from 12/6/11 to 12/13/11. On 12/6/11 at 5:30 P.M. nurse's notes indicated Resident #40 was straining to have a BM, physician was notified and a new order was received for 2 tabs of 8.5 mg of Senna to be given routinely at bedtime. No outcome of this medicine was shown and no further intervention was initiated until a stool was listed on the record dated 12/13/11.			
	A nurse's note dated 12/9/11, indicated that an assessment was done, abdomen was soft and bowel sounds were active in 4 quadrants.			
	During the dates of 12/13/11 to 12/18/11 (5 days) no stool was indicated, and from 12/18/11 to 12/27/11 (9 days) no bowel			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC A. BUILDING	00	COMPI	LETED	
	1557	57	B. WING 01/27/201:				
	PROVIDER OR SUPPLIER		7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN 46237			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ENT OF DEFICIENCIES T BE PERCEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	movements were noted there were no intervent						
	During an interview wi 12/27/12 at 12:45 P.M. copy of an assessment notes dated 12/24/11 ir abdomen of Resident # soft and non tender and sounds in all 4 quadrant 3.1-37(a)	, she provided a done in nursing idicating the 40 at that time was I there were bowel					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155757	B. WING		01/27/2012	
	PROVIDER OR SUPPLIEI ATE VILLAGE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  7510 ROSEGATE DR INDIANAPOLIS, IN 46237			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	DE CAMPANIA DE LA CAMPANIA DE	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0314 SS=G	a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that and a resident has receives necessal promote healing, prevent new sores. Based on observation record review, the aresident who expressure ulcers within 19 of 5 residents retinated at the resident sample. Findings included The clinical recordereviewed on 1/2 indicated the restacility on 1/6/12. The diagnoses for but were not limit hematuria, hyperthypothyroidism, mellitus type II,  The 1/18/12 additional resident in the sample of the sam	ord for Resident #47 was 6/12 at 10:30 a.m. and sident was admitted to the 2.  or Resident #47 included, sited to: sepsis, rglycemia, allergic rhinitis, diabetes	F0314	What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice?  Resident #47 was immediately assessed and treated per physician order upidentification of the wound(s) his risk for skin breakdown caplan was updated with new individualized interventions. Resident #47 no longer residented facility.  How will you identify other residents having the potentiato be affected by the same deficient practice and what corrective action will be take.  Pressure wound risk assessments for all residents have been updated to reflect current accurate resident information.  Care plans for resident identified as high-risk for developing skin breakdown heen reviewed to ensure appropriate interventions are place.  A facility-wide skin swe has been completed to identified.	n  con and are es at ial en? s ave in eep	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLETED	
		155757	A. BUIL			01/27/2012	
		1.00.0.	B. WING	_		0	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					OSEGATE DR		
ROSEG	ATE VILLAGE			INDIANAPOLIS, IN 46237			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETI	ION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112	
	physical assist, v	walk in room - activity			residents with pressure areas		
	occurred only or	nce or twice/one person			to ensure appropriate treatme		
	physical assist, l	Is the resident at risk for			and services to promote heali have been ordered.	ng	
		sure ulcers/yes, Does this			Residents with orders f	or 1/4	
		e or more unhealed			rails to help with bed mobility	51 74	
					have been identified and beds	s	
	_	at stage 1 or higher/no,			checked to ensure 1/4 rails are	in	
	`	erview for Mental Status)			place.		
	score/15 (highes	•			What measures will be put in	nto	
	indicating reside	ent is cognitively intact).			place or what systemic		
					changes you will make to		
	The 1/6/12 entry on the Interdisciplinary				ensure that the deficient		
	Progress Notes i				practice does not recur?		
		e (symbol for "no") areas			<ul> <li>Residents who are new admissions/readmissions will</li> </ul>		
		ry healthy looking." The			have weekly pressure risk		
					assessments completed by a		
	_	Admission Assessment			licensed nurse for the first x 4		
		lent (symbol for "with")			weeks.		
	(symbol for "no	") skin issues noted".			· Residents who are new	,	
	The 1/6/12 Press	sure Wound Risk			admissions/readmissions will		
	assessment indic	cated the resident was at			have a head to toe skin		
	risk for develop	ing skin breakdown.			assessment completed within		
	_	plan with appropriate			first 24 hours of admission by licensed nurse.	a	
	interventions.	pian with appropriate			Licensed nurses will		
	interventions.				conduct rounds on residents v	vith	
	TT 1/6/10 1:				care plan interventions for turi		
		breakdown careplan			and reposition to ensure		
		sident was at risk for skin			interventions are occurring. T		
	breakdown due	to decreased mobility and			and reposition services will be	:	
	incontinent of be	owel. The goal indicated			documented on the resident		
	on the care plan	was resident would be			MAR.  Rounds will be conduct	od	
	free from skin b				weekly by the Rehab Services		
		cated on the care plan			Manager and/or designee to	<b>'</b>	
	* *	•			ensure that siderails are in pla	ice	
		reposition at least every			as ordered.		
		rails in grab bar position			Nursing staff will be		
	to promote inde	pendence in bed.			in-serviced by Director of Nurs	sing	
	1				and/or designee on February		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLET	ED
		155757	A. BUI B. WIN			01/27/20	12
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			OSEGATE DR		
POSEG/	ATE VILLAGE				APOLIS, IN 46237		
					Al OLIO, IN 40201		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The 1/9/12 entry	y on the Interdisciplinary			2012 on risk factors for skin	_	
	progress Notes i	indicated "IDT met to			breakdown and interventions t prevent pressure wound	0	
	review resident	for siderails. Determined			development.		
	1/4 rails in grab	bar position for assistance			How the corrective action (s)		
	_	th") bed mobility"			will be monitored to ensure t		
		. ,			deficient practice will not rec	ur,	
	The CNA Skin	Check Detail Report			i.e., what quality assurance		
		#1 saw a new skin			program will be put into plac	e?	
					A CQI audit tool will be		
	•	on the buttocks area on			utilized to monitor compliance		
	1/21/12.				with prevention interventions or residents at high-risk for	DT	
					developing pressure wounds b	nv	
	During interview with CNA #1 on				the Director of Nursing and/or	,,	
	1/26/12 at 3:15	p.m., she indicated the			designee. Resident observation	ns	
	area referenced	above was bleeding when			will be completed weekly X 4		
		1/21/12 and she told RN			weeks, monthly X 2 months, a		
	#1 right away.				quarterly thereafter for at least		
					two quarters.  Results of these evaluate	tion	
	The 1/21/12 Clai	n Igaya Investigation form			processes will be presented to		
		n Issue Investigation form			the CQI Committee monthly to		
		7 completed by RN #1			review for compliance and		
		ea on the coccyx was 0.6			follow-up. Identified		
	cm x 0.3 cm x 0				noncompliance may result in s		
	granulation. Qu	estion #4 on this form			re-education and/or disciplinar	у	
	asked "After int	erviewing staff, how			action.		
	would you conc	lude the injury happened					
	(if not witnessed	d)?" The written answer					
		d area on coccyx was a					
		re area." The written					
	_	n to prevent recurrence on					
		EPC cream (incontinent					
		g direct pressure from					
	coccyx as much	as possible."					
	The 1/25/12 Wo	ound Progress Note					
	indicated 3 press	sure woundsa stage III					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULT  A. BUILDII  B. WING		00	(X3) DATE : COMPL 01/27/	ETED	
	PROVIDER OR SUPPLIER		S 7	510 RC	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN 46237	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	3.0 cm x 0.1 cm, buttock wound n cm x 0.1 cm, and	an unstageable left neasuring 2.0 cm x 2.0 I an unstageable sacrum g 0.7 cm x 0.5 cm x 0.1					
	made on 1/27/12 affected area was pink surrounding of red spots. The the right buttock an index fingerna was covering the wound disenablis	at 11:35 a.m. The sthe size of a fist with the wounds with areas e actual wound size on looked about the size of all bed. The EPC cream pink area just above this ang full view of the entire rails were affixed to ed during this					
	1/27/12 at 1:35 p was no evidence	with the DON on n.m., she indicated there to prove Resident #47 epositioned as care					
	indicated staff ne repositioned him he resided at the never had sideral myself. I wish I	1/27/12 at 2:00 p.m. He					

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	of CORRECTION IDENTIFICATION NUMBER:  155757	A. BUILDING  B. WING	00	COMPL - 01/27/	ETED		
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	more difficult to stand. There's pain on my bottom." During this interview, maintenance came in to install siderails at 2:10 p.m. on 1/27/12. The resident stated to maintenance "Oh, it's a little late coming."  3.1-40(a)(1)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155757				01/27/	2012
			B. WIN		ADDRESS SET STATE THE SORE		
NAME OF I	PROVIDER OR SUPPLIE	R		l	ADDRESS, CITY, STATE, ZIP CODE		
DOOE O	YTE VIII I AOE		7510 ROSEGATE DR				
ROSEGA	ATE VILLAGE			INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CO			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG			DATE
F0323	The facility must	ensure that the resident					
SS=E		ains as free of accident					
	· ·	ssible; and each resident					
	receives adequat						
	ì	es to prevent accidents.	1 500	•		.	
Based on observation, interview and		F03	23	What corrective action(s) will		02/26/2012	
	record review, the	he facility failed to ensure			be accomplished for those residents found to have been		
	chemicals and sl	harps were stored securely			affected by the deficient		
	to prevent acces	s by 25 of 32 residents on			practice?		
	the secured dem	entia unit who were			The 2 bottles of suntan		
	confused and me	obile. (Residents #7, 8, 9,			lotion and 3 gardening tools were immediately secured behind a		
		8, 20, 21, 22, 23, 25, 26,					
· · · · · · · · · · · · · · · · · · ·					locked door.		
	27, 28, 29, 30, 32, 35, 36, 37, 33, 24, and				All other doors within th		
	11)				facility were immediately chec		
					to ensure there were no hazar within the environment for	as	
	Findings include	ed:			confused and mobile residents	e e	
					How will you identify other	J.	
	An environment	al tour of the facility was			residents having the potential	al	
	conducted on 1/	27/12 at 10:25 a.m. with			to be affected by the same		
	the Maintenance	e Supervisor and the			deficient practice and what		
		Laundry Supervisor. The			corrective action will be take	n?	
		closet on the Cottage			· All residents who are		
		•			confused and mobile within th	е	
	· ·	ementia unit, was observed			facility have been identified.		
		A sign was posted on the			Safety assessments of their environments have been		
		Please keep this door			conducted to ensure they are	free	
	locked at all tim	es." Upon entrance of the			of accident hazards.		
	unlocked door, a	a clear, opened bag was			What measures will be put in	nto	
	on the floor with	n 2 bottles of suntan lotion			place or what systemic		
	and 3 gardening	tools (2 hand shovels and			changes you will make to		
		ide, clearly visible			ensure that the deficient		
	through the bag.	•			practice does not recur?		
	anough the bag.				· An in-service will be		
	D	and the store of the st			provided by the Memory Care Facilitator and/or designee on		
	_	w at this time with the			February 14, 2012 to all facilit		
		aundry Supervisor, she			staff on identifying and securing	•	
	indicated the do	or was supposed to be			hazardous items within reside	•	

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Facility ID: 011149

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PRINTED: 02/17/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION  A. BUILDING  00	(X3) DATE SURVEY  COMPLETED
	155757	B. WING	01/27/2012
	PROVIDER OR SUPPLIER  ATE VILLAGE  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL	STREET ADDRESS, CITY, STATE, ZIP 7510 ROSEGATE DR INDIANAPOLIS, IN 46237  ID PROVIDER'S PLAN OF CE (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ORRECTION (X5) SHOULD BE COMPLETION
TAG	locked. During interview with the Maintenance Supervisor at this time, he indicated the clear bag shouldn't have been in there.  On 1/27/12 at 1:30 p.m., the DON provided a list of 25 ambulatory/self-propelled residents (Residents #7, 8, 9, 10, 13, 14, 16, 18, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30, 32, 35, 36, 37, 33, 24, and 11) on the Cottage Unit with severe or moderate cognitive impairment.  3.1-45(a)(1)	areas.  Facility rounds conducted daily by the Care Facilitator and/or to ensure hazardous properly secured with confused and mobile have access to.  How the corrective a will be monitored to deficient practice will.  A CQI audit to utilized by the Mainted Director and/or design monitor compliance we securing hazardous in areas in which confused mobile residents have Resident areas will be weekly X 4 weeks, memonths, and quarterly for at least two quarters for at least two quarters of the CQI Committee in review for compliance may be reducted in a compliance may be reducted in a compliance may be reducted in and/or of action.	will be e Memory or designee items are in areas that residents  action (s) ensure the Il not recur, surance into place? ol will be mance nee to with properly tems in sed and e access to. e observed onthly X 2 y thereafter ers. ee evaluation sented to monthly to e and result in staff

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Event ID: S4YX11

Facility ID: 011149

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET			ETED	
		155757	B. WIN		01/27/2012		
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OSEGATE DR		
DOSEG A	TE VILLAGE				IAPOLIS, IN 46237		
ROSEGA				INDIAN	IAF OLIS, IN 40237		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0325		nt's comprehensive					
SS=D		acility must ensure that a					
	resident -						
		eptable parameters of					
		such as body weight and					
	•	ess the resident's clinical trates that this is not					
	possible; and	itates triat triis is riot					
		erapeutic diet when there is					
	a nutritional proble	•					
	Based on intervio	ew and record review, the	F03	25	What corrective action(s) will	J	02/26/2012
	facility failed to	recognize and address a			be accomplished for those		
	weight loss for p	otential concerns for 1 of			residents found to have been	•	
	4 residents review	wed for weight in a total			affected by the deficient		
	sample of 24. (R	•			practice? An interdisciplinary review	2///	
	sumple of 2 i. (it	esident #30)			was conducted for Resident #		
	F: 1: : 1 1				to address potential concerns		
	Findings include	:			her identified weight loss.		
					Resident's nutritional care plar	า	
	The clinical reco	rd for Resident #50 was			was reviewed and updated to		
	reviewed on 1/25	5/12 at 10:30 a.m.			include individualized		
					interventions. Resident's weig		
	The diagnoses fo	or Resident #50 included,			has stabilized at this time and	she	
	but were not limit	· · · · · · · · · · · · · · · · · · ·			remains within her ideal body		
					weight.		
		ure, constipation,			How will you identify other	<b>.</b> 1	
	hypertension, ost	* *			residents having the potentia to be affected by the same	11	
	hypothyroidism,	and right fibula/tibia			deficient practice and what		
	fracture.				corrective action will be take	n?	
					· All resident weights wer		
	The 12/19/11 we	ight care plan for			evaluated to ensure that any		
		icated the goal was for			losses were		
		•			identified/recognized. An		
	the resident to ha	· ·			interdisciplinary review was		
	_	reater than 5% in 30 days			conducted for all residents with	า	
	and an approach	was to monitor weight.			weight loss including the		
					development of a nutritional ca	are	
	The Weights Det	tail Report indicated			plan with individualized		
		ighed 167 lbs on 12/5/11			interventions. These residents will continue to be reviewed by		
	1100100110 1100 WO	-5	1		I will continue to be reviewed by	/	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPLETED
		155757	B. WING			01/27/2012
	NOT WIND OF	<u> </u>	<del>'</del> T		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				OSEGATE DR	
	ATE VILLAGE			INDIAN	APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE
		2/14/11. It indicated the			the interdisciplinary team to	tiv o
	resident was wei	ghed twice on 12/24/11			ensure interventions are effect and nutritional goals have bee	
	at 150 lbs and 14	9.8 lbs. respectively. No			met.	
	information coul	d be found in the clinical			What measures will be put in	to I
		e this 10.17% weight loss			place or what systemic	
		12/24/11, this 5.06%			changes you will make to	
		·			ensure that the deficient	
	~	12/14/11 to 12/24/11, or			practice does not recur?	
		loss from 12/5/11 to			Any residents who	
	12/14/11 was rec	eognized and addressed			experience a 5% or more weig	
	for potential con-	cerns.			loss in 30 days will be reviewe	
					by the interdisciplinary team for	or
	During interview	with the Dietary			current nutritional status and	
	~	5/12 at 11:15 a.m., she			implementation of individualize interventions.	ea
		no excuse, but she was			Meal Managers will more	nitor
					a meal delivery daily for those	
		r 12/24/11 and that she			residents experiencing weight	
	^ ~	to have taken over for			loss to ensure compliance with	
	her and addresse	d this. She indicated the			receiving individualized nutrition	onal
	weight loss issue	was not addressed until			interventions.	
	she spoke with R	tesident #50 on 1/6/12.			· An in-service will be	
	•				provided by the Registered	
	3.1-46(a)(1)				Dietitian and/or designee on	
	σ.1- <del>1</del> υ(α)(1)				February 22, 2012 to the interdisciplinary team member	
					regarding facility policy for	°
					reviewing residents with weigh	nt or
l					nutritional concerns.	
					How the corrective action (s)	
					will be monitored to ensure t	he
l					deficient practice will not rec	ur,
İ					i.e., what quality assurance	
					program will be put into plac	e?
					· A CQI audit tool will be	
					utilized by the Director of Nurs	ing
İ					and/or designee to monitor	for
					compliance with facility policy	
					weight monitoring and IDT rev of residents with weight and	ICAA
					nutritional concerns weekly X	4

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	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	ONSTRUCTION 00	COMPLETED
		155757	B. WING		01/27/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
ROSEGA	TE VILLAGE			OSEGATE DR IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	weeks, monthly X 2 months, quarterly thereafter for at lead two quarters.  Results of these evaluates processes will be presented the CQI Committee monthly review for compliance and follow-up. Identified noncompliance may result in re-education and/or disciplinaction.	and staff
			I	1	l

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155757	B. WING		01/27/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			ROSEGATE DR	
POSEGV	TE VILLAGE			NAPOLIS, IN 46237	
			INDIA	•Al OLIO, IIV +0207	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0329		ug regimen must be free			
SS=D		drugs. An unnecessary			
		hen used in excessive			
		iplicate therapy); or for n; or without adequate			
		nout adequate indications			
		e presence of adverse			
	consequences which indicate the dose				
	•	d or discontinued; or any			
	combinations of th	e reasons above.			
	·	rehensive assessment of a			
		ry must ensure that			
	residents who have not used antipsychotic drugs are not given these drugs unless				
		therapy is necessary to			
		ndition as diagnosed and			
	-	e clinical record; and			
		antipsychotic drugs			
		ose reductions, and			
		ntions, unless clinically			
		an effort to discontinue			
	these drugs.		ļ	<b>\</b>	
	Based on interview	ew and record review, the	F0329	What corrective action(s) will	02/26/2012
	facility failed to	ensure a pre and post		be accomplished for those	
	assessment for a	dministered prn (as		residents found to have been affected by the deficient	1
	needed) pain med	dication was utilized to		practice? • Resident #133 wa	ie
		eness and need, for 1 of 5		immediately assessed for pain	
	residents reviewe	,		and the efficacy of pain	
		nistration in a sample of		medication with no negative	
		1		outcomes noted. How will you	ı
	24 (Resident #13	(3).		identify other residents havir	ng
				the potential to be affected by	
	Findings include	:		the same deficient practice a	
				what corrective action will be	
	The clinical reco	rd for Resident #133 was		taken? · All residents receivin	•
	reviewed on 1/25	5/12 at 2:40 p.m.		prn pain medication have been	
				identified. Pain assessments was be completed for these resider	
	The diagnoses fo	ar Resident #133		to ensure their drug regimen d	
	The diagnoses 10	n Resident #133		not include unnecessary drugs	
				1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155757			A. BUI	LDING	ONSTRUCTION 00	(X3) DATE SURVE COMPLETED 01/27/2012	
		133737	B. WIN			01/21/2012	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
DOCEO!	NTE VIII I ACE				OSEGATE DR		
RUSEGA	ATE VILLAGE			INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COM	PLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG		12	DATE
	included, but we	ere not limited to:			and care plans updated to refl	ect	
	osteoporosis, ge	neralized arthritis, and			current resident		
	degenerative joi	nt disease.			status/interventions. What		
					measures will be put into pla		
	Δ recanitulation	of the October and			or what systemic changes yo will make to ensure that the	ou	
	•				deficient practice does not		
		MAR (Medication			recur? · Residents identified	<sub>vith</sub>	
		Record) indicated there			prn pain medication orders wil		
		PRN (as needed)			have pre and post assessmen		
	Hydrocodone/A	cetaminophen 5/325, 2			documented on MAR and/or		
	tablets by mouth	n every 4 hours as needed			nurses notes to include reasor		
	for moderate to	severe breakthrough pain.			for administration, intervention		
Hydrocodone 5/325 was given on 10/4/11				and effectiveness of administe			
	(no time indicated), 10/21/11 (no time				pain medication. · An in-service		
	`	11/10/11 (no time			will be completed by the Direc of Nursing and/or designee on		
	· · · · · · · · · · · · · · · · · · ·	•			February 16, 2012 to licensed		
	· · · · · · · · · · · · · · · · · · ·	ere was no documentation			nurses on completing and		
		esident was assessed for			documenting pre- and		
	the location or in	ntensity/nature of the pain			post-assessments for prn pain		
	prior to adminis	tering the pain medication			medication administration. · T	he	
	or for the effecti	iveness of the medication			Director of Nursing Services		
	after the medica	tion was given.			and/or designee will assign a licensed nurse to review the		
					MAR's daily of all residents wh		
	A nain care nlan	indicated an approach,			receive a prn pain medication		
		as to observe effectiveness			ensure compliance with		
		led) medications.			documentation of pre and pos		
	of PKN (as fieed	ied) medications.			pain assessments. How the		
					corrective action (s) will be		
		with the DoN (Director of			monitored to ensure the		
	Nursing), on 1/2	27/12 at 09:20 a.m., she			deficient practice will not rec	ur,	
	indicated that sh	ne expects staff to			i.e., what quality assurance		
	document the ef	fectiveness of prn pain			program will be put into plac  · A CQI audit tool will be utiliz		
	medication.	_			by the Director of Nursing and		
					designee to monitor compliance		
					of pre and post assessments f		
	3.1-48(a)(3)				prn pain medications. MAR an		
	3.1-48(a)(4)				Nurses notes observations wil	be	
	[ 5.1 10(0)(1)				completed weekly X 4 weeks,		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 01/27/2012
	ROVIDER OR SUPPLIEF		7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5)  DE COMPLETION  DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	monthly X 2 months, and quarterly thereafter for at letwo quarters. Results of evaluation processes will be presented to the CQI Commonthly to review for compand follow-up. Identified noncompliance may result re-education and/or disciplaction.	east these le mittee bliance in staff

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			
		155757			01/27/2012	
			B. WING	NET ADDRESS SITE STATE SID CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP CODE		
DOOE O	YTE VIII I AOE			0 ROSEGATE DR		
ROSEGA	ATE VILLAGE		INDI	IANAPOLIS, IN 46237		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0371	The facility must	-				
SS=D	(1) Procure food to	from sources approved or				
		actory by Federal, State or				
	local authorities;					
		e, distribute and serve food				
	under sanitary co		700-1	\	U	
Based on observation and interview, the		F0371	What corrective action(s) wi	II 02/26/2012		
	facility failed to	ensure an employee used		be accomplished for those residents found to have bee	_	
	the appropriate	utensils in a manner to			II	
	prevent the pote	ential spread of infection		affected by the deficient practice?		
	or decrease pote	_		· Immediate education w	rae l	
	_	while serving a ready to eat		provided to C.N.A. #2 about u		
				appropriate utensils to serve	loning	
		t # 143. This deficient		ready to eat foods to resident	s.	
	practice affected	d 1 of 17 residents who		How will you identify other		
	were assisted wi	ith eating meals in the		residents having the potenti	al	
	Restorative Din	ing Room.		to be affected by the same		
				deficient practice and what		
	Findings include	a·		corrective action will be take	en?	
	Tindings include	<b>.</b>		· All residents who requi	re	
				assistance with ready to eat for	oods	
	_	observation on 1/26/12 at		have been identified.		
	11:30 A.M. CN.	A # 2 was observed in the		· Nursing staff that assis		
	Restorative Din	ing Room removing a		residents with eating have be		
	muffin from a w	rapper with bare hands		in-serviced on the proper met for serving ready to eat foods		
		n the dish of Resident #		as to prevent contamination a		
	143.	the dish of resident h		possible spread of infection.		
	143.			What measures will be put in	nto	
				place or what systemic		
	_	view on 1/26/12 at 1:00		changes you will make to		
	P.M. with CNA	# 2, she acknowledged		ensure that the deficient		
	that she touched	the muffin with her bare		practice does not recur?		
	hands. She indi	cated she had been trained		· An in-service will be		
		d with bare hands on		conducted by the Dietary		
				Services Manager and/or		
	1	ds, but it had been a long		designee on February 23, 20		
	time since that i	nservicing.		facility staff that serve food to		
				residents and/or assist reside		
	3.1-21(i)(3)			with eating. The in-service wi		

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	OF CORRECTION	IDENTIFICATION NUMBER:  155757	A. BUILDING B. WING	00	COMPLETED 01/27/2012
	ROVIDER OR SUPPLIER		7510 R	ADDRESS, CITY, STATE, ZIP CODE COSEGATE DR JAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				serving ready to eat foods so a to prevent contamination and possible spread of infection.  Meal observations will be conducted by the Dietary Services Manager and/or designee every other day to monitor for food being served under sanitary conditions.  How the corrective action (s) will be monitored to ensure the deficient practice will not recipie, what quality assurance program will be put into place.  A CQI audit tool will be utilized by the Infection Controd Coordinator and/or designee the monitor compliance with utilizing appropriate utensils to serve ready to eat foods to residents Meal service will be observed weekly X 4 weeks, monthly X months, and quarterly thereafted for at least two quarters.  Results of these evalual processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in sere-education and/or disciplination action.	he cur, e? ol oo ng s. 2 eer tion

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155757	A. BUII B. WIN			01/27/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t		l	OSEGATE DR		
POSEGA	ATE VILLAGE				IAPOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0372	_	lispose of garbage and					
SS=F	refuse properly.	and the second				.	
		ation and interview, the	F03	72	What corrective action(s) will be accomplished for those	ı	02/26/2012
	facility failed to	properly contain refuse in			be accomplished for those residents found to have been		
	dumpsters with o	closed side doors. This			affected by the deficient	•	
	had the potential	to affect 145 of 145			practice?		
	residents in the f	acility.			The 3 bags of garbage	on	
		,			the ground next to the dumpst		
	Findings include				were placed in the dumpster.		
	Tillulings illetude	•			· The Maintenance Direc		
		1. 0.1 0.11.			was educated about immediat	•	
		al tour of the facility was			disposing of garbage that is no	ot	
		27/12 at 10:25 a.m. with			properly contained in the		
	the Maintenance	Supervisor. At 11:10			dumpster and closing dumpster doors when observed open.	er	
	a.m. on 1/27/12,	during the environmental			How will you identify other		
	tour, there was a	n observation of a facility			residents having the potentia	al	
	•	d 3 bags of garbage on			to be affected by the same		
	-	to the dumpster with			deficient practice and what		
	_	them. The side doors			corrective action will be take	n?	
					· All residents have the		
	were opened on				potential to be affected by the		
	dumpster with re	efuse in the dumpster.			alleged deficient practice.		
					Executive Director has	to	
	During interview	with the Maintenance			contacted facility trash vendor explore alternative options for		
	Supervisor on 1/	27/12 at 11:10 a.m., he			properly containing		
	indicated the doc	ors on the sides of the			garbage/refuse.		
	dumpster should	have been closed and the			What measures will be put in	ito	
	-	ould not have been on the			place or what systemic		
		indicated his staff			changes you will make to		
	_	the garbage every			ensure that the deficient		
					practice does not recur?		
	morning to ensui	re it was contained.			· An in-service will be		
					conducted by the Maintenance	Э	
	During an observ	vation on 1/27/12 at 1:50			Director and/or designee on February 14, 2012 to all facility	v	
	p.m., the same fa	ncility dumpster had 2			staff about proper disposal of	у	
	bags of garbage	on the ground next to the			garbage along with maintainin	q	
		efuse in each of them and			dumpster door closure.	5	
			1		1 '		

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	OF CORRECTION IDENTIFICATION NUMBER:  155757	A. BUILDING  B. WING		COMPLETED 01/27/2012
	PROVIDER OR SUPPLIER  ATE VILLAGE	STREET ADDRESS, 7510 ROSEGAT INDIANAPOLIS,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PRFFIX (EACH	ROVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	1 side door was opened with refuse in the dumpster.  During interview with the Maintenance Supervisor on 1/27/12 at 1:50 p.m., he indicated one of his staff was supposed to take care of the garbage after the first observation at 11:10 a.m. on 1/27/12.  3.1-21(i)(5)	dumpsiby the land/or garbag and du closed. How the will be deficie i.e., where programs is a second with the deficie i.e., where programs is a second with the deficie i.e., where programs is a second with the condition of the c	me corrective action (s) monitored to ensure the ent practice will not recent quality assurance as will be put into place A CQI audit tool will be by the Infection Control nator and/or designee to recompliance with proper all and containment of pe/refuse. The dumpster ill be observed weekly a monthly X 2 months, and y thereafter for at least	e of he ur, e? I o er r ( 4 nd

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155757	B. WING		01/27/2012
NAME OF I	PROVIDER OR SUPPLIE	D .	STREET	Γ ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	FROVIDER OR SUFFEIE	K	7510 I	ROSEGATE DR	
ROSEGA	ATE VILLAGE		INDIA	NAPOLIS, IN 46237	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	<del>                                     </del>	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0514 SS=D	The facility must each resident in a professional stan complete; accura accessible; and so the clinical recordinformation to ide of the resident's acare and services preadmission sor State; and progres Based on recording facility failed to containing an active actual experience facility. This were sident (Resident)	maintain clinical records on accordance with accepted dards and practices that are stely documented; readily systematically organized.  If d must contain sufficient entify the resident; a record assessments; the plan of a provided; the results of any reening conducted by the	F0514	What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice?  Resident C was immediately assessed for appropriate oral health as well trach maintenance with no	II 02/26/2012 n
	of 24. Findings includ	e:		negative outcomes noted.  How will you identify other residents having the potenti to be affected by the same	al
	Review of Resid	dent #C's record on		deficient practice and what corrective action will be take	an?
		P.M. indicated the		· All residents with physi	
	following:			ordered oral care due to being	
		was observed as being		NPO were identified and	
	incomplete for o	oral care on every shift,		assessed for appropriate oral health.	
	ordered by reca	p of physician's order		There are no other	
	dated 1/1/12 (du	ue to resident being NPO).		residents who require trach ca	are
	Oral care was n	ot documented on 1/7, 12,		services at this time.	
	13 for 1st shift	(10:00 P.M. to 6:00 A.M.)		What measures will be put in	nto
		9 for 2nd shift (6:00 A.M.		place or what systemic	
		nd on 1/23 on 3rd shift		changes you will make to	
	(2:00 P.M. to 10			ensure that the deficient practice does not recur?	
	(2.001.101.101)	J. OO 1 .IVI. J.		Residents requiring	
				physician ordered oral care d	ue

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DII	NC	00	COMPLI	ETED
		155757	A. BUILDII	NU		01/27/	2012
			B. WING	TDEET A	DDDEGG GITY GTATE ZID GODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
50050	TE \ ///   A O E				DSEGATE DR		
ROSEGA	ATE VILLAGE		"	NDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	T	CAG	DEFICIENCY)		DATE
	During a review	of a Trach Care record			to being NPO will have oral ca	re	
	_	documentation was			services provided and		
					documented on the resident M	IAR	
		ig incomplete for care on			(medication administration		
	every shift, orde	•			record).		
	physician's order	r dated 1/1/12 for			Residents requiring trac		
	Hydrogen Perox	3% solution for trach			care will have services provide		
	care every shift.	This care was not			and documented on the reside MAR.	ent	
	l	naving been done on 1/3,			· An in-service will be		
		1st shift (10:00 P.M. to			completed by the Director of		
		`			Nursing and/or designee on		
	, · · · · · · · · · · · · · · · · · · ·	4, 15, 18, 19 for 2nd shift			February 21, 2012 to licensed		
	`	00 P.M.) and on 1/23 for			nurses on documentation		
	3rd shift (2:00 P	.M. to 10:00 P.M.).			requirements of services		
					provided.		
	On 1/24/12 at 3:	35 P.M. during an			· The Director of Nursing		
		PN # 1, reviewing			Services and/or designee will		
					assign a licensed nurse to revi	iew	
		cord, she indicated that			the medication and treatment		
	she had not work				administration records daily of		
	previously to exp	plain why it wasn't			residents who require oral care due to being NPO as well as	=	
	documented app	ropriately, but that she			those requiring trach care.		
	was taught if it v	vasn't documented it			How the corrective action (s)		
	_	that it was probably just			will be monitored to ensure t		
	not documented.				deficient practice will not rec		
	not documented.	•			i.e., what quality assurance	,	
					program will be put into plac	e?	
					· A CQI audit tool will be		
					utilized by the Director of Nurs	ing	
					and/or designee to monitor		
					compliance of documented ora		
					and trach care services weekly		
					4 weeks, monthly X 2 months,		
					and quarterly thereafter for at		
					least two quarters.  Results of these evaluations	tion	
					processes will be presented to		
					the CQI Committee monthly to		
					review for compliance and		
					follow-up. Identified		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MU A. BUII B. WIN	DING	ONSTRUCTION 00	(X3) DATE COMPL <b>01/27</b>	ETED
	PROVIDER OR SUPPLIE ATE VILLAGE	R		7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	3.1-50(a)(2)				noncompliance may result in s re-education and/or disciplinar action.		

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	of Correction	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/27/2012	
	PROVIDER OR SUPPLIER ATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237			
(X4) ID PREFIX TAG F9999	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
פפפיו	STATE FINDING:  3.1-14 Personnel  1. A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two step	F9999	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  Employees #1 and #2 wunidentified. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take.  An audit of all active employee files has been completed to ensure that reco include a documented negative tuberculin skin test result within the preceding twelve months of prior to the employees identified who do not have a documented negative tuberculosis skin test result as outlined above, a tuberculin skin test will be administered test as prescribed by state rule.  What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  An in-service will be conducted by the Director of Nursing and/or designee on February 22, 2012 to the Infect Control Coordinator and Payro Coordinator regarding the required screening for health of workers.	vere  al  an?  rds e n or . d d d d t to  ction oll	

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STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SUI	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLET	COMPLETED		
155757		A. BUILDING B. WING		01/27/20	01/27/2012			
		1	_	EET ADDRESS, CITY, STATE, ZIP CO	DE .			
NAME OF F	PROVIDER OR SUPPLIEF	R		0 ROSEGATE DR				
ROSEGATE VILLAGE				INDIANAPOLIS, IN 46237				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRIAT		PROPRIATE	COMPLETION		
TAG			TAG	·	ac will be	DATE		
	method. If the 1st step is negative, a 2nd				New hire processes will be developed by the Executive			
	•	erformed one (1) to three	Director to ensure that all screening requirements ha					
	(3) weeks after t	he first step. The						
	frequency of rep	eat will depend on the		been met prior to an em	•			
	risk of infection	with tuberculosis.		beginning work.				
				· A tickler file system				
	This State Rule was not met as evidenced		developed by the Executive Director to track annual due dates					
	by:			for current employees to				
	-J·			tuberculin skin tests are	Charle			
	Dagad an ragard	review and interview, the		administered on an on-g	oing			
		-		basis.				
		appropriately screen		How the corrective acti	on (s)			
		iberculosis. This		will be monitored to en				
	•	employees whose files		deficient practice will n				
	were reviewed. (	(Employees #1 and #2)		i.e., what quality assura				
				program will be put into	-			
	Findings include	e:		utilized by the Executive				
				and/or designee to moni				
	The Administrat	or provided a completed		compliance with appropri				
		for all current employees		employee screenings for				
	on 1/27/12 at 12			tuberculosis. New hire p				
	011 1/2// 12 at 12	.001		file audits will be conducted to all new ampleyees we				
	The file of emple	oyee #1 was reviewed on		to all new employees wo 90 days. An audit of the				
	-	P.M. and indicated the		employee tuberculin skir				
				tickler file system will be				
	•	n completed at the time of		conducted weekly X 4 w				
		11/11/11 but the 2nd step		monthly X 2 months, and				
	was not marked.			quarterly thereafter for a	t least			
				two quarters.  Results of these e	valuation			
	The file of emplo	oyee #2 was reviewed on		processes will be preser				
	1/27/12 at 1:00 I	P.M. and indicated the 1st		the CQI Committee mon				
	step was comple	eted at the time of		review for compliance ar				
	employment on	10/20/11 but the 2nd step		follow-up. Identified				
	was not marked.	*		noncompliance may res				
				re-education and/or disc action.	ipiinary			
	During an interv	riew with the		action.				
		10 11 17 1011 0110	ı	i i	<b>I</b>			

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	DF CORRECTION IDENTIFICATION NUMBER:  155757	A. BUILDING  B. WING	COMPLETED 01/27/2012			
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) D BE COMPLETION DATE			
	Administrator on 1/27/12 at 4:00 P.M. she indicated the facility had no further information regarding the TB testing of employees #1 and 2.  3.1-14(t)					

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